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MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: MAY 3, 2018

Re: S.3148-A (Savino)/A.2646-A (Simotas) – An act to amend the insurance law, in relation to insurance coverage of in vitro fertilization and other fertility preservation treatments.

This legislation, S.3148-A/A.2646-A, would mandate health plans provide coverage of in vitro fertilization (IVF). The New York Health Plan Association (HPA) opposes this legislation because health insurance mandates result in increased costs and increased premiums at a time we are seeking affordability.

The bill mandates coverage of IVF procedures as a new coverage benefit. New York, in compliance with the Affordable Care Act (ACA), is required to cover ten Essential Health Benefits (EHBs). Addition of IVF would be an eleventh EHB. Federal law requires any state that adds coverage benefits above the ten EHBs to pay for such additional services with state funds. No appropriation is included in this legislation, nor is there any language to make clear that the families and small business premium payers are exempt from this coverage cost in compliance with the ACA.

Our member health plans recognize the type of infertility services is important to women in meeting their family planning needs. Currently, the Department of Financial Services is studying how best to include in vitro fertilization in the state's existing infertility coverage mandate. Given the significant financial impact that expanding the IVF mandate would have on the cost of coverage for employers and consumers it is critical for that examination to take place to understand the efficacy and cost implications of such services. The process should be allowed to take place to provide a more complete picture of the financial impact and clinical appropriateness.

IVF procedures typically cost $10,000 to $15,000, so the fiscal impact of this mandate must be considered. While advocates of the proposal seek to dismiss the cost impact as "pennies" per policy, those pennies add up. When Massachusetts studied a proposal to expand its infertility coverage in 2009, the Division of Health Care Finance and Policy estimated a premium increase of $4.4M-$33.1M – in a state with a much smaller population. A study of a Pennsylvania mandate proposal estimated the cost impact at a minimum of $44M-49M, and said it could go as high as $123M if utilization increased, as was seen in Massachusetts.

This issue of increased utilization is also important. When someone else – insurance, in this case – pays for a service or treatment, utilization goes up. When the Department of Insurance (now DFS) studied the impact of New York's 1997 Chiropractic Care Act (conducted by William Mercer and issued in May 2000), it found chiropractic service utilization increased "significantly," which also resulted in cost increases. The concerns about utilization and accompanying cost increases are made even more worrisome when you consider this proposal is open-ended. Unlike other states that have enacted IVF mandates, this proposal has no limits on the number of attempts that would be covered or age of the mother, or caps on lifetime cost of the benefit.

Like other mandated benefit bills, the cost of this legislation will be disproportionately fall on small businesses, as expanding existing mandated benefits force them to include benefits they and their workforce may not want or need, exacerbating the challenge they face to find affordable health care options. Mandated benefit bills pertain only to fully-insured policies, which are purchased either by individuals who purchase coverage on their own or receive it through a small or medium-sized business. Large companies typically "self-insure," providing employee health benefits by directly paying health care claims to providers. They are governed by the Federal Employee Retirement Income Security Act (ERISA) and are not subject to state mandated benefits. Included in ERISA is a provision preventing states from deeming employee health benefit plans to be in the business of insurance for the purpose of state oversight, which preempts states from regulating these plans.

One reason that large employers typically self-insure is to avoid covering certain mandated benefits. This exemption offers self-insured employers greater control over the particular benefits they cover for their employees. Today, roughly 50 percent of the commercial market in New York is covered under a self-insured plan. As more employers self-insure, state laws mandating specific types of benefits and services, or expanding existing mandates as these bills would, affect an increasingly smaller portion of the privately insured marketplace and fall largely on small and medium-sized employers.

Finally, in 2007, the New York State Health Care Quality and Cost Containment Commission was established to analyze the impact any proposed mandate would have on health insurance costs and quality of care. This analysis would look at current plan practices with regard to the benefit, review medical literature related to the potential impact on health care quality, and assess the possible premium impact of the proposed mandated benefits as well as the potential for avoided costs through early detection and treatment of conditions or more cost-effective delivery of medical services. At this time, not all of the appointees to the commission have been submitted. In the absence of the Commission being convened and funded to examine this and other mandated benefit bills, no independent analysis examining the cost and efficacy of this mandate exists.

At a time when many New Yorkers are struggling to afford the health insurance coverage they have, imposing new, costly mandated benefits will exacerbate that challenge. As DFS is currently studying this issue, this bill is ill advised and we would urge you to say no to S.3149-A/A.2646-A.